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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION THREE

SAMEY NEKRAWESH, Plaintiff and Appellant, v. VALERIE ARNO, Defendant and Respondent.	A142243 (Alameda County Super. Ct. No. HG12632554)

Plaintiff Samey Nekrawesh appeals from a judgment entered in favor of defendant Valerie Arno on his complaint for negligent operation of an automobile. Following trial, a jury found that defendant's admitted negligence had caused plaintiff no damages. Plaintiff contends the trial court erred in excluding evidence of plaintiff's medical and noneconomic damages. We agree and thus shall reverse the judgment.[1]

Factual and Procedural History

On June 8, 2010, plaintiff and defendant were involved in an automobile accident in which defendant's vehicle rear-ended plaintiff's vehicle. Plaintiff filed a personal injury complaint against defendant alleging a single cause of action for negligent operation of a motor vehicle.

[1] Plaintiff presents numerous additional challenges to the judgment, including contentions that the court erred (1) in quashing his subpoena of defendant's expert witness, (2) in denying his motions to continue trial, (3) in permitting defendant to introduce evidence obtained after the discovery cut-off date, and (4) in denying his post-trial motions. These issues need not be considered in light of our conclusions with respect to the evidentiary rulings.

Prior to trial, the court made a number of rulings that severely restricted the evidence of damages that plaintiff was permitted to present. As discussed more fully below, the court ruled that plaintiff's treating physicians, who were disclosed as percipient expert witnesses, could not testify as to the reasonable value of the medical treatment they provided. The court also excluded plaintiff's medical bills on the ground that the bills were irrelevant and inadmissible to establish the reasonable value of plaintiff's medical expenses. Finally, the court found that plaintiff was not insured at the time of the accident and thus under Civil Code section 3333.4 could not present evidence of or recover noneconomic damages, including pain and suffering and lost earning capacity

At trial, defendant admitted her negligence in causing the rear-end collision. Under the court's in limine rulings, plaintiff's only evidence of damages was testimony that the accident prevented him from working, resulting in $30,000 in lost wages, which defendant argued was not credible. The jury returned a unanimous verdict in favor of defendant. In a special verdict, the jury found that defendant's negligence was not a substantial factor in causing harm to plaintiff.[2] The court entered judgment in defendant's favor based on the jury's "special verdict finding that [defendant's] negligence was not a substantial factor in causing plaintiff's wage loss from 12/5/12 to 2/18/14." Following the denial of multiple posttrial motions, plaintiff timely filed a notice of appeal.

Discussion

Plaintiff contends that the trial court's in limine rulings erroneously and prejudicially precluded him from presenting evidence of the full extent of his damages.

1. *Medical Expenses*

"A person who undergoes necessary medical treatment for tortiously caused injuries suffers an economic loss by taking on liability for the costs of treatment. Hence,

[2] Having found that defendant's negligence was not a substantial factor in causing harm to plaintiff, the jury did not reach the additional questions on the special verdict form that asked about plaintiff's contributory negligence and plaintiff's "total damages for loss of earnings from December 5, 2012 through February 18, 2014."

any reasonable charges for treatment the injured person has paid or, having incurred, still owes the medical provider are recoverable as economic damages." (*Howell v. Hamilton Meats & Provisions, Inc*. (2011) 52 Cal. 4th 541, 551 (*Howell*).) A plaintiff's recovery for past medical expenses is limited, however, by the reasonable value of the services provided. (*Id*. at p. 555.) Thus, "[d]amages for past medical expenses are limited to the lesser of (1) the amount paid or incurred for past medical expenses and (2) the reasonable value of the services." (*Corenbaum v. Lampkin* (2013) 215 Cal. App. 4th 1308, 1325-1326 (*Corenbaum*), citing *Howell,* 52 Cal.4th at p. 556.)

In the trial court, both counsel agreed that plaintiff did not have medical insurance at the time of his treatment and had not paid any of his medical bills. In *Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, 1330-31, the court observed that "the measure of damages for uninsured plaintiffs who have not paid their medical bills will usually turn on a wide-ranging inquiry into the reasonable value of medical services provided, because uninsured plaintiffs will typically incur standard, nondiscounted charges that will be challenged as unreasonable by defendants."

Prior to trial, defendant moved for an order precluding plaintiff from presenting "any evidence through an expert as to the reasonable value of medical care and services provided to plaintiff" on the ground that "such testimony goes beyond the scope of what would be anticipated of a nonretained expert and plaintiff did not disclose any retained expert to testify on that issue." In support of the motion, defendant offered documentation showing that plaintiff's expert declaration listed eight "treating doctors or health care providers" but none were designated as "retained" and no expert declarations under Code of Civil Procedure section 2034.260, subdivision (c) were served.[3] At the hearing,

[3] Code of Civil Procedure section 2034.260, subdivision (c) provides: "If any witness on the list is an expert as described in subdivision (b) of Section 2034.210, the exchange shall also include or be accompanied by an expert witness declaration signed only by the attorney for the party designating the expert, or by that party if that party has no attorney. This declaration shall be under penalty of perjury and shall contain: [¶] (1) A brief narrative statement of the qualifications of each expert. [¶] (2) A brief narrative statement of the general substance of the testimony that the expert is expected to give. [¶] (3) A

defendant argued that only a properly retained and disclosed expert could opine at trial on the reasonable value of plaintiff's medical treatment. Plaintiff disagreed, arguing that each of his treating doctors could testify as to the reasonableness of their own medical bills and that he was not required to retain an additional expert for that purpose. After taking the matter under submission, the court ruled, "The doctors may only testify as to . . . only their personal experience and training and the experience and opinions they have regarding treatment, but not as to the . . . reasonableness of the amount of the cost of the care." Relying on *Schreiber v. Estate of Kiser* (1999) 22 Cal.4th 31 (*Schreiber*), the court found that such testimony falls squarely within the purview of a retained expert.

In *Schreiber*, the court held that a nonretained, treating physician "may testify as to any opinions formed on the basis of facts independently acquired and informed by his training, skill, and experience . . . [,] includ[ing] opinions regarding causation and standard of care because such issues are inherent in a physician's work." (*Schreiber, supra,* 22 Cal.4th at p. 39.) The court in *Schreiber* explained, "A treating physician is a percipient expert, but that does not mean that his testimony is limited only to personal observations. Rather, like any other expert, he may provide both fact and opinion testimony. As the legislative history clarifies, what distinguishes the treating physician from a retained expert is not the content of the testimony, but the context in which he became familiar with the plaintiff's injuries that were ultimately the subject of litigation, and which form the factual basis for the medical opinion. . . . A treating physician is not consulted for litigation purposes, but rather learns of the plaintiff's injuries and medical history because of the underlying physician-patient relationship." (*Id*. at pp. 35-36.)

Citing *Schreiber*, the trial court in this case reasoned that testimony regarding the reasonable value of medical services "has nothing to do with the expert's role in treating

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representation that the expert has agreed to testify at the trial. [¶] (4) A representation that the expert will be sufficiently familiar with the pending action to submit to a meaningful oral deposition concerning the specific testimony, including any opinion and its basis, that the expert is expected to give at trial. [¶] (5) A statement of the expert's hourly and daily fee for providing deposition testimony and for consulting with the retaining attorney."

plaintiff and everything to do with preparation for litigation and trial." The court later explained with respect to one of plaintiff's doctors, "[H]e's a surgeon. He doesn't know about the billing, how they set it up. [¶] . . . [¶] That's not his pursuit. The medical office does that."

Plaintiff contends that *Ochoa v. Dorado* (2014) 228 Cal.App.4th 120 (*Ochoa*), decided after the court's ruling in this case, demonstrates the court's error. In *Ochoa,* the court held that under the reasoning in *Schreiber,* a treating physician, testifying as a nonretained expert, may opine "as to the reasonable value of services that the treating physician either provided to the plaintiff or became familiar with independently of the litigation, assuming that the treating physician is qualified to offer an expert opinion on reasonable value. A treating physician who has gained special knowledge concerning the market value of medical services through his or her own practice or other means independent of the litigation may testify on the reasonable value of services that he or she provided or became familiar with as a treating physician, rather than as a litigation consultant, without the necessity of an expert witness declaration. To the extent that a treating physician became familiar with services provided to the plaintiff or other facts for the purpose of forming and expressing an opinion in anticipation of litigation or in preparation for trial, however, he or she acts as a retained expert. An expert witness declaration is required for such a treating physician to the extent that he or she testifies as a retained expert." (*Id.* at p. 140.) Plaintiff asserts that at least one of his experts "is also a teacher who teaches about the costs of certain medical items/services" but he was not given "an opportunity to explain [his] knowledge about their own billing" to the court.

Defendant contends *Ochoa* was wrongly decided. She argues that the decision in *Ochoa* reflects an improper application of the holding in *Schreiber* because unlike the standard of care, the reasonable value of medical services cannot be determined from "facts independently acquired and informed by [the physician's] training, skill, and experience." She continues, "In fact, respondent submits that medical care providers have no reason or cause to become 'informed' or 'experts' in the field of reasonable value of medical costs *until litigation ensues and they are asked to form such an opinion*. While a

doctor can form medical, and perhaps causation opinions during the normal course of treatment of an injured patient, the billing is taken care of [by] support staff until such a time as the doctor has to become involved, such as here where there is a lawsuit, and which time he or she has to learn the treatment, the billing rates, what the market will bear, etc. This is therefore necessarily facts and information gained 'for the purpose of forming and expressing an opinion in anticipation of litigation or in preparation for trial' and requires a proper disclosure as a retained expert."

Defendant's argument, however, is not based on evidence in the record. The basis of the treating physician's opinion is subject to inquiry at a qualification hearing. No such record was made in this case because the trial court concluded incorrectly that testimony regarding the reasonable value of medical services is categorically outside the scope of a treating physician's permissible testimony. The court erred in excluding testimony by plaintiff's treating physicians without first determining if they were qualified to offer an opinion on the reasonable value of the medical services they rendered.

As noted above, the trial court also excluded all evidence of plaintiff's unpaid medical bills on the ground that they were irrelevant. Citing *Howell supra,* 52 Cal.4th 541 and *Corenbaum, supra,* 215 Cal.App.4th 1308, the court explained that introduction of medical bills was an "improper method" of establishing the reasonable value of the medical treatment because "[a] doctor can charge anything they want" and "the fact that a doctor chooses to charge an amount, does not make that amount reasonable."

In *Howell*, the court held that "[a]n injured plaintiff whose medical expenses are paid through private insurance may recover as economic damages no more than the amounts paid by the plaintiff or his or her insurer for the medical services received or still owing at the time of trial." (*Howell, supra,* 52 Cal.4th at p. 566.) The court explained that insured plaintiffs incur only the fee amount negotiated by their insurer, not the initial billed amount so that insured plaintiffs may not recover more than their actual loss, i.e., the amount incurred and paid to settle their medical bills. (*Id*. at p. 555.) The court continued, "It follows from our holding that when a medical care provider has, by agreement with the plaintiff's private health insurer, accepted as full payment for the

plaintiff's care an amount less than the provider's full bill, evidence of that amount is relevant to prove the plaintiff's damages for past medical expenses and, assuming it satisfies other rules of evidence, is admissible at trial. . . . Where the provider has, by prior agreement, accepted less than a billed amount as full payment, evidence of the full billed amount is not itself relevant on the issue of past medical expenses." (*Id*. at p. 567.)

In *Corenbaum*, the court relied on *Howell* in holding that in an action involving an insured plaintiff, evidence of the full amount billed for past medical services was not relevant and was therefore inadmissible to prove past medical expenses, future medical expenses, and/or noneconomic damages. (*Corenbaum, supra,* 215 Cal.App.4th at pp. 1328-1333.) Notably, however, the court distinguished *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288, 1295-1296, in which prior to the decision in *Howell* the court held that evidence of the full amount billed is admissible to determine the reasonable value of past medical services, on the ground that "the plaintiffs in that case, who apparently had no health insurance, remained fully liable to their medical providers for the full amount billed despite the providers' sale of their accounts to a medical finance company at a discount." (*Corenbaum, supra*, at p. 1328, fn. 10.)

In *Bermudez v. Ciolek, supra,* 237 Cal.App.4th 1311, a case involving an uninsured plaintiff, the court emphasized the difference between the admissibility of medical bills and sufficiency of the evidence to establish the reasonable value of medical services. The court observed, "To be clear, . . . neither *Howell*, *supra*, 52 Cal.4th 541, nor *Corenbaum, supra,* 215 Cal.App.4th 1308, holds that billed amounts are inadmissible in cases involving uninsured plaintiffs. Bermudez's uninsured status meant that billed amounts were relevant to the amount he incurred (unlike insured plaintiffs, who really only incur the lower amount negotiated by their insurer). The billed amounts are also relevant and admissible with regard to the reasonable value of Bermudez's medical expenses . . . . [Citation.] The admissibility of the billed amount is consistent with the 'full range of fees' being relevant in determining the reasonable value of services in the health care marketplace." (*Bermudez, supra,* at p. 1335.) The court advised however, "initial medical bills are generally insufficient on their own as a basis for determining the

reasonable value of medical services. . . . [A] plaintiff who relies solely on evidence of unpaid medical charges will not meet his burden of proving the reasonable value of medical damages with substantial evidence." (*Ibid*.)

As noted above, the parties agreed in the trial court that plaintiff did not have medical insurance at the time of the accident and treatment. Thus, his unpaid medical bills were admissible and the trial court erred in excluding them.

The court's two evidentiary rulings, precluding plaintiff from presenting his full claims to the jury, were clearly prejudicial. The defense verdict was based on the jury's finding that the accident caused plaintiff no damages, yet the plaintiff had been prevented from presenting evidence of his damages. For this reason alone the judgment must be reversed.

2. *Noneconomic Damages*

Civil Code Section 3333.4 "prohibits uninsured motorists . . . from collecting noneconomic damages in any action arising out of the operation or use of a motor vehicle." (*Yoshioka v. Superior Court* (1997) 58 Cal.App.4th 972, 978.)[4] The purpose of the statute "is to 'limit recovery of noneconomic damages for those drivers that break the law' thereby encouraging uninsured owners and motorists to purchase liability insurance and ensuring that 'law abiding citizens will no longer be required to carry the burden of paying for those citizens that *choose to directly defy the current state of the law*.' " (*Savnik v. Hall* (1999) 74 Cal.App.4th 733, 742.)

Prior to trial, defendant filed a motion to exclude plaintiff's noneconomic damages based on his failure to obtain liability insurance on the vehicle he owned and was driving

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[4] Civil Code section 3333.4, subdivision (a) provides, with an exception not applicable in this case, that "in any action to recover damages arising out of the operation or use of a motor vehicle, a person shall not recover non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damages if any of the following applies: [¶] . . . [¶] (2) The injured person was the owner of a vehicle involved in the accident and the vehicle was not insured as required by the financial responsibility laws of this state. . . ."

All further statutory references are to the Civil Code unless otherwise noted.

when the accident occurred. Plaintiff challenges the court's determination that he was uninsured at the time of the accident.

According to plaintiff's discovery responses, the accident occurred on June 8, 2010, while plaintiff was driving a Honda Accord that he owned. Plaintiff claimed that he was insured at the time under Workman's Auto Insurance Company, policy No. 5002456-00. Plaintiff does not dispute that on the declaration page his policy lists only a Toyota Corolla as the insured vehicle. He claims, however, that he purchased the Honda eight days prior to the accident and that he was insured under the "automatic insurance clause" in his policy. The policy provides: "Coverage for a 'newly acquired auto' is provided as described below. If you ask us to insure a 'newly acquired auto' after a specified time period described below has elapsed, any coverage we provide for a 'newly acquired auto' will begin at the time you request the coverage. [¶] For any coverage provided in this policy except Coverage For Damage To Your Auto, a 'newly acquired auto' will have the broadest coverage we now provide for any vehicle shown in the Declarations. Coverage begins on the date you become the owner. However, for this coverage to apply to a 'newly acquired auto' which is in addition to any vehicle shown in the Declarations, you must ask us to insure it within 14 days after you become the owner. [¶] If a 'newly acquired auto' replaces a vehicle shown in the Declarations, coverage is provided for this vehicle without your having to ask us to insure it." Plaintiff admits that he cannot recall whether he notified his insurer of his new vehicle. His policy expired two days after the accident and was not renewed.

The trial court granted defendant's motion, noting that there was no evidence that plaintiff notified his carrier of the new car within 14 days of its purchase as required by the policy. Plaintiff contends the court erred in interpreting the policy as requiring him to notify his insurance company about the newly acquired vehicle in order to establish he was insured at the time of the accident. We review the court's interpretation of the insurance policy de novo. (*The Villa Los Alamos Homeowners Assn. v. State Farm Gen. Ins. Co*. (2011) 198 Cal.App.4th 522, 529-530.**)**

"The automatic insurance clause, found in most standard automobile liability policies, is designed to provide insured owners with continuous liability protection in light of their recognized custom of acquiring other cars by replacement and new purchases during the life of their policies. As universally recognized by the courts, an 'automobile' [citation], to qualify for automatic liability insurance coverage, must be acquired by the named insured [citation] during the policy period [citation] as either a 'replacement' for the vehicle described in the policy, or as an additional vehicle where the named insured 'insures all automobiles owned' by him with the underwriter from whom automatic insurance coverage is sought [citation], and in addition, timely notice of acquisition must be given the insurer within the period specified (often referred to by the courts as the 'grace' period) in the particular policy." (39 A.L.R.4th 229.) The purpose of the provision "is to provide insurance coverage when an owned automobile is not described in a policy and to provide coverage for the newly acquired car at the earliest time the insured needs protection." (8A Couch on Ins. § 117:2.) "The clause is equally important to insurers by preventing an increase in the risk assumed by the insurer except upon such terms as the insurer itself has specified." (*Ibid*.)

In *Birch v. Harbor Ins. Co*. (1954) 126 Cal.App.2d 714, 719, the court held that an automatic insurance provision provides "automatic coverage after the delivery of the newly acquired automobile during the period in which notice may be given, and that the requirement of notice is merely a condition subsequent which must be complied with in order to keep such coverage in effect beyond that period." The court explained, "At best, these provisions were somewhat ambiguous. A reasonable person might reasonably assume from the language used that automatic coverage of a newly acquired automobile was provided for 30 days, which would then cease in the event the required notice was not given. Under any other theory, no additional protection was given the assured and this provision would be meaningless and useless. If notice was required to effect any coverage, even during the 30-day period, the insured would be just where he would have been in the absence of any such provision. Without that provision he could apply for insurance on the other car and the company could accept or reject his application. If, as

appellant argues, there was no coverage during the 30 days and the company was free to refuse the risk even if notice was given, no protection was added by this provision. Unless this provision was inserted in the policy for the purpose of deception, and this should not be assumed, it meant something and was intended to confer some benefit on the insured. It may reasonably be interpreted as intended to furnish an additional protection on a temporary basis; to be in effect, in appellant's language, 'until a reasonable opportunity was had to notify the company.' This reasonable opportunity was fixed at 30 days. If appellant's intention was otherwise, this provision should have been eliminated from the policy and such other intention more clearly expressed." (*Id*. at pp. 720-721; see also 39 A.L.R.4th 229 ["The courts are virtually unanimous in the view that an insured's failure to give his insurer timely notice of acquiring a replacement or additional vehicle bars automatic insurance coverage for liability arising after the notice or 'grace' period expires [citation], and are likewise unanimous in expressing the view that such failure by the insured does not affect automatic coverage for liability arising during the notice period [citation], the courts in the latter cases recognizing that notice is a condition subsequent to coverage of a newly acquired vehicle beyond the notice period specified in the policy."].)

Defendant contends that "*Birch Harbor* and its progeny" were wrongly decided. Defendant argues, "The *Birch Harbor* analysis, finding that coverage during the notice period simply exists, and that the notice requirement is simply a condition *subsequent* to coverage beyond the notice period, conflates and confuses conditions precedent and subsequent, fails to acknowledge that the notice requirement is both a condition precedent and a condition subsequent, ignores the plain language of the policy, and rewards a consumer for failing to comply with the policy requirements."

Whether the notice provision is considered a condition precedent to the continued coverage after the initial 14 days or a condition subsequent which terminates further coverage if not met, is immaterial. The conditional nature of the coverage relates only to insurance coverage after the grace period. Insurance coverage for the first 14 days is automatic and not conditional. The policy clearly states that coverage

begins on the date you become the owner. Defendant's attempt to make that coverage conditional based on subsequent notification injects unnecessary ambiguity into the contract and ignores longstanding, well-established interpretation of similar provisions.

Defendant also argues that *Birch Harbor* is factually distinguishable because plaintiff cancelled rather than renewed his policy. However, whether plaintiff cancelled his policy after the accident is irrelevant to the interpretation of the terms of the policy that was in effect at the time of the accident.

Finally, defendant argues that "while *Birch Harbor* and its progeny benefit the victims of the tortfeasor who seek to execute judgment on the carrier, such a benefit should not be extended to this [plaintiff] who would then reap an unfair benefit." Our interpretation of the policy does not result in an "unfair benefit" for plaintiff. Civil Code section 3333.4 is intended to penalize uninsured drivers for breaking the law. Plaintiff did not break the law. He was insured at the time of the accident. Accordingly, he is entitled to seek noneconomic damages as any other insured driver who is the victim of another driver's negligence. The trial court's ruling precluded plaintiff from introducing evidence of such damages and the judgment must be reversed on this ground as well.

Disposition

The judgment is reversed. Plaintiff shall recover his costs on appeal.

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Pollak, Acting P.J.

We concur:

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Siggins, J.

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Jenkins, J.